STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

CHAPTER 761

AN ACT SB 787

Relating to health care; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. As used in sections 1 to 4 of this 1991 Act:

(1) "Health care organization" means a home health agency, hospice program, hospital, long term care facility or health maintenance organization.

(2) "Health maintenance organization" has that meaning given in ORS 750.005, except that "health maintenance organization" includes only those organizations that participate in the federal Medicare or Medicaid programs.

(3) "Home health agency" has that meaning given in ORS 443.005.

(4) "Hospice program" has that meaning given in ORS 443.850.

(5) "Hospital" has that meaning given in ORS 442.015 (13), except that "hospital" does not include a special inpatient care facility.

(6) "Long term care facility" has that meaning given in ORS 442.015 (13), except that "long term care facility" does not include an intermediate care facility for individuals with mental retardation.

SECTION 2. Subject to the provisions of sections 3 and 4 of this 1991 Act, all health care organizations shall maintain written policies and procedures, applicable to all capable individuals 18 years of age or older who are receiving health care by or through the health care organization, that provide for:

(1) Delivering to those individuals the following information and materials, in written form, without recommendation:

(a) Information on the rights of the individual under Oregon law to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care;

(b) Information on the policies of the health care organization with respect to the implementation of the rights of the individual under Oregon law to make health care decisions;

(c) A copy of the directive form set forth in ORS 127.610 and a copy of the power of attorney for health care form set forth in ORS 127.530, along with a disclaimer attached to each form in at least 16-point bold type stating "You do not have to fill out and sign this form."; and

(d) The name of a person who can provide additional information concerning the forms for directives and powers of attorney for health care.

(2) Documenting in a prominent place in the individual's medical record whether the individual has executed a directive or a power of attorney for health care.

(3) Insuring compliance by the health care organization with Oregon law relating to directives and powers of attorney for health care.

(4) Educating the staff and the community on issues relating to directives and powers of attorney for health care.

SECTION 3. The written information described in section 2 (1) of this 1991 Act shall be provided:

(1) By hospitals, not later than five days after an individual is admitted as an inpatient, but in any event before discharge;

(2) By long term care facilities, not later than five days after an individual is admitted as a resident, but in any event before discharge;

(3) By a home health agency or a hospice program, not later than 15 days after the initial provision of care by the agency or program but in any event before ceasing to provide care; and

(4) By a health maintenance organization, not later than the time allowed under federal law.

SECTION 4. (1) The requirements of sections 1 to 4 of this 1991 Act are in addition to any requirements that may be imposed under federal law, but this 1991 Act shall be interpreted in a fashion consistent with the Patient Self-Determination Act, enacted by sections 4206 and 4751 of Public Law 101-508. Nothing in this 1991 Act requires any health care organization, or any employee or agent of a health care organization, to act in a manner inconsistent with federal law or contrary to individual religious or philosophical beliefs.

(2) No health care organization shall be subject to criminal prosecution or civil liability for failure to comply with this 1991 Act.

SECTION 5. Sections 1 to 4 of this Act are added to and made a part of ORS 127.505 to 127.585.

SECTION 6. If Senate Bill 494 becomes law section 5 of this Act is repealed and section 7 of this Act is enacted in lieu thereof.

SECTION 7. Sections 1 to 4 of this 1991 Act are added to and made a part of sections 1 to 21, chapter ___, Oregon Laws 1991 (Enrolled Senate Bill 494).

SECTION 8. This Act takes effect on December 1, 1991.

SECTION 9. Sections 1 to 4 of this Act are repealed December 1, 1993.

Approved by the Governor August 5, 1991
Filed in the office of Secretary of State August 5, 1991

SECTIONS 1-4 will follow ORS 127-650 as a "Note" entitled "Obligations of Health Care Organizations". This is based on Section 8 and 9 of this act.

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127.530 Form of power of attorney. A written power of attorney for health care shall provide no other authority than the authority to make health care decisions on behalf of the principal and shall be in the following form:

POWER OF ATTORNEY FOR HEALTH CARE

I appoint_____, whose address is _____, and whose telephone number is_____, as my attorney-in-fact for health care decisions. I appoint_____, whose address is _____, and whose telephone number is_____, as my alternative attorney-in-fact for health care decisions. I authorize my attorney-in-fact appointed by this document to make health care decisions for me when I am incapable of making my own health care decisions. I have read the warning below and understand the consequences of appointing a power of attorney for health care.

I direct that my attorney-in-fact comply with the following instructions or limitations: _____

In addition, I direct that my attorney-in-fact have authority to make decisions regarding the following:

____Withholding or withdrawal of life-sustaining procedures with the understanding that death may result.

____Withholding or withdrawal of artificially administered hydration or nutrition or both with the understanding that dehydration, malnutrition and death may result.

_____
(Signature of person making appointment/Date)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is the person appointed as attorney-in-fact by this document or the principal's attending physician. Witnessed By:

_____ _____
(Signature of Witness/Date) (Printed Name of Witness)

_____ _____
(Signature of Witness/Date) (Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY

I accept this appointment and agree to serve as attorney-in-fact for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner, and that I have a duty to inform the principal's attending physician promptly upon any revocation.

_____
(Signature of Attorney-in-fact/Date)

_____
(Printed name)

_____
(Signature of Alternate Attorney-in-fact/Date)

_____
(Printed name)

WARNING TO PERSON APPOINTING A POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. It creates a power of attorney for health care. Before signing this document, you should know these important facts:

This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you, subject to any limitations, specifications or statement of your desires that you include in this document.

For this document to be effective, your attorney-in-fact must accept the appointment in writing.

The person you designate in this document has a duty to act consistently with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in a manner consistent with what the person in good faith believes to be in your best interest. The person you designate in this document does, however, have the right to withdraw from this duty at any time.

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127.610 Execution and revocation of directive; form; witness qualifications and responsibility. (1) An individual of sound mind and 18 years of age or older may at any time execute or reexecute a directive directing the withholding or withdrawal of life-sustaining procedures should the declarant become a qualified patient. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____ (month, year). I _____, being of sound mind, wilfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

1. If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians, one of whom is the attending physician, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County and State of Residence _____

I hereby witness this directive and attest that:

(1) I personally know the Declarant and believe the Declarant to be of sound mind.

(2) To the best of my knowledge, at the time of the execution of this directive, I:

(a) Am not related to the Declarant by blood or marriage,

(b) Do not have any claim on the estate of the Declarant,

(c) Am not entitled to any portion of the Declarant's estate by any will or by operation of law, and

(d) Am not a physician attending the Declarant, a person employed by a physician attending the Declarant or a person employed by a health facility in which the Declarant is a patient.

(3) I understand that if I have not witnessed this directive in good faith I may be responsible for any damages that arise out of giving this directive its intended effect.

Witness _____

Witness _____

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(2) A directive made pursuant to subsection (1) of this section is only valid if signed by the declarant in the presence of two attesting witnesses who, at the time the directive is executed, are not:

(a) Related to the declarant by blood or marriage;

(b) Entitled to any portion of the estate of the declarant upon the decease thereof under any will or codicil of the declarant or by operation of law at the time of the execution of the directive;

(c) The attending physician or an employee of the attending physician or of a health facility in which the declarant is a patient; or

(d) Persons who at the time of the execution of the directive have a claim against any portion of the estate of the declarant upon the declarant's decease.

(3) One of the witnesses, if the declarant is a patient in a long term care facility at the time the directive is executed, shall be an individual designated by the Department of Human Resources for the purpose of determining that the declarant is not so insulated from the voluntary decision-making role that the declarant is not capable of wilfully and voluntarily executing a directive.

(4) A witness who does not attest a directive in good faith shall be liable for any damages that arise from giving effect to an invalid directive.

(5) A directive made pursuant to ORS 127.605 to 127.650 and 97.990 (5) to (7) may be revoked at any time by the declarant without regard to mental state or competency by any of the following methods:

(a) By being burned, torn, canceled, obliterated or otherwise destroyed by the declarant or by some person in the declarant's presence and by direction of the declarant.

(b) By a written revocation of the declarant expressing intent to revoke, signed and dated by the declarant.

(c) By a verbal expression by the declarant of intent to revoke the directive.

(6) Unless revoked, a directive shall be effective from the date of execution. If the declarant has executed more than one directive, the last directive to be executed shall control. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders the declarant able to communicate with the attending physician. [Formerly 97.955]

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YOUR RIGHT TO MAKE HEALTH CARE DECISIONS IN OREGON

DO I HAVE TO DO WHATEVER MY DOCTOR RECOMMENDS? No. You have a right to accept or refuse any proposed medical tests or treatment.

HOW WILL I KNOW HOW TO DECIDE? Your doctor will tell you what treatment or testing he or she recommends. Your doctor will then ask if you want to know more. If you do, your doctor will tell you about the treatment or test, the available alternatives and the material risks. When you have enough information, you decide whether to have the test or treatment.

HOW CAN I PLAN AHEAD FOR A TIME WHEN I MAY BE UNABLE TO MAKE DECISIONS? Oregon has only two official forms you can sign to cover future situations where you are unable to decide. A Directive to Physician is a legal statement that you do NOT want artificial life support which would only postpone your death when you are terminally ill. A Power of Attorney for Health Care lets you designate someone you trust, your representative, to make your health care decisions for you when you can't do so yourself. It allows your representative to give most directions you could have given. Your representative cannot act for you unless you become unable to make your own decisions.

HOW DO THESE HEALTH CARE PLANNING FORMS TAKE EFFECT? If you are an adult able to make your own decisions, you can sign either or both of these forms. **You do not have to fill out and sign either form** if you don't want to. However, if you do, your doctor must follow it or allow you to be transferred to a doctor who will. The forms will not affect your insurance.

HOW DO I APPOINT SOMEONE ELSE TO ACT FOR ME? By using a "Power of Attorney for Health Care" form, you may select another adult as your health care representative. You may also appoint an alternate, if you wish. The representative and any alternate must sign the form agreeing to serve. You must also decide what authority you want to give those persons. Your representative is not obligated to pay your medical bills.

HOW DO I OBTAIN AND SIGN MY WRITTEN HEALTH CARE DOCUMENTS? Health care facilities and some stationery stores have the official forms. In Oregon, the only reliable way to be sure your wishes are followed is to use the official forms. Do not change them except by filling in the blanks. Don't add anything about money or property. Each must be signed by you and two witnesses who must satisfy special requirements. Read and follow the directions. Send a copy to your doctor and to anyone you choose as a representative. Keep the original where it can be found.

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